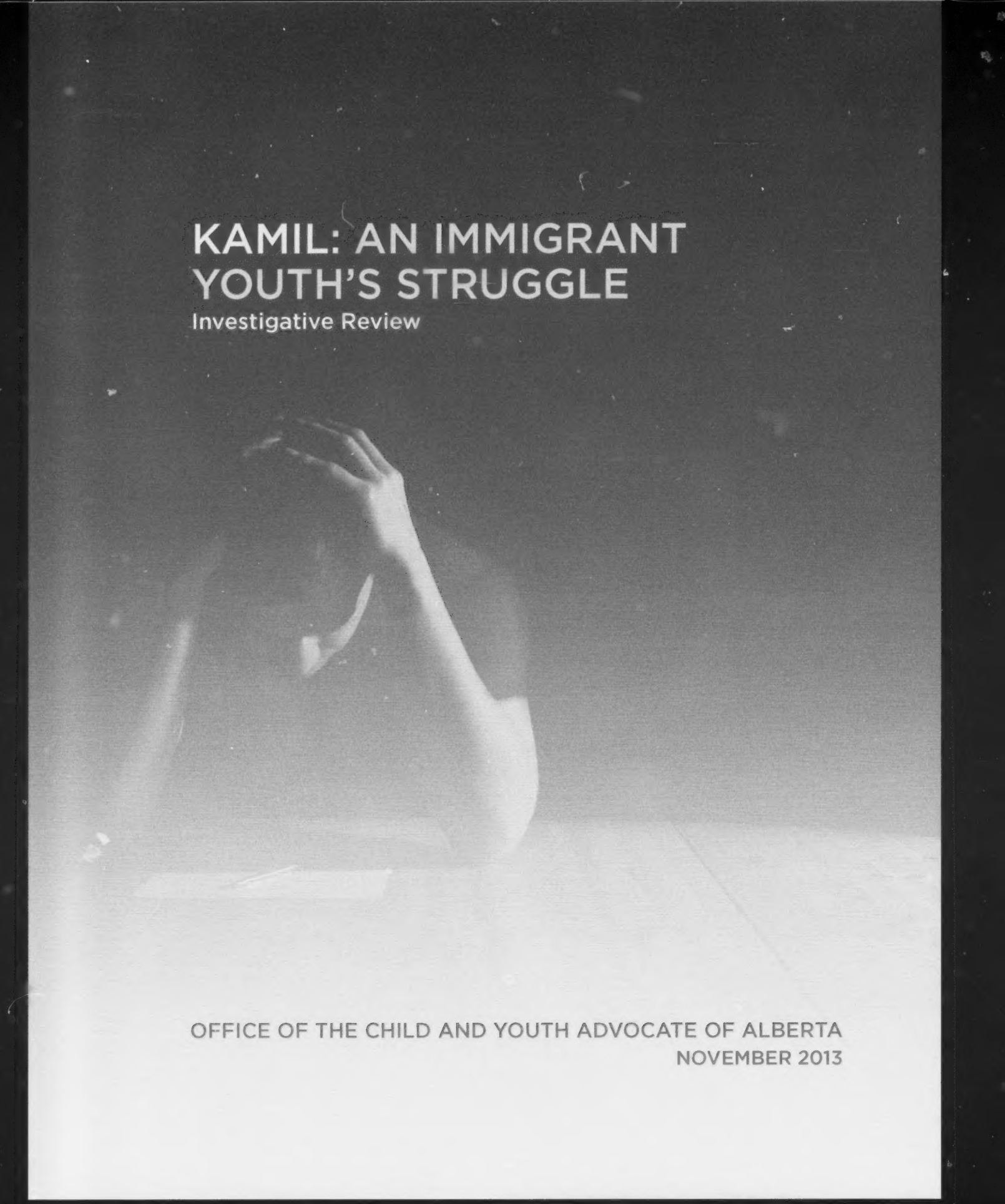
KAMIL: AN IMMIGRANT YOUTH'S STRUGGLE

Investigative Review



OFFICE OF THE CHILD AND YOUTH ADVOCATE OF ALBERTA
NOVEMBER 2013

say

specialized advocacy
for **youngPeople**

Under my authority and duty as set out in the *Child and Youth Advocate Act*, I am providing the following Investigative Review concerning the passing of a young person who was, at the time, receiving designated services from the Government of Alberta. Consistent with section 15 of the Act, the purpose of this report is to learn from this tragic event and recommend ways of improving Alberta's child intervention system.

While this is a public report, my office has taken great care to protect the privacy of the family members of the young person involved. The names used in this report are pseudonyms and the report refrains from disclosing information that could be used to identify the young person or his family.

Accordingly, I would request that readers and interested parties, including the media respect this privacy and not focus on identifying the individuals and locations involved in this matter.

The loss of this young person is tragic. He came to Canada for a better life. Just over four years later he died by suicide. His family, friends and others who knew him have lived with the grief of his death. I completed this Investigative Review because it is important that we learn from this tragedy so we do all we can do to prevent similar tragedies in the future.

[original signed by Del Graff]

Del Graff
Child and Youth Advocate

Office of the Child and Youth Advocate

805 Peace Hills Trust Tower, 10011 109 Street NW Edmonton, AB T5J 3S8 Canada
Main-line 780.644.8281 Fax 780.644.8833 www.alberta.ca/advocate

CONTENTS

EXECUTIVE SUMMARY 4

INTRODUCTION 6
The Office of the Child and Youth Advocate 6
Investigative Reviews 6
About This Review 7

BACKGROUND 8
About Kamil 8
About Kamil's Family 8

HISTORY OF INVOLVEMENT WITH CHILD INTERVENTION SERVICES 9
Overview 9
Services Provided to Kamil at 13 Years Old 9
Services Provided to Kamil at 14 Years Old 11
Services Provided to Kamil at 15 Years Old 14
Services Provided to Kamil at 16 Years Old 16
Services Provided to Kamil the Day Before His Death 19

DISCUSSION AND RECOMMENDATIONS 21
Understanding the cultural context 22
Building protective factors in children and youth 24
Managing medication for mental health 25
Enhancing the quality of decision-making 28

CLOSING REMARKS FROM THE ADVOCATE 30

APPENDICES 31
Appendix 1: Terms of Reference 31
Appendix 2: Committee Membership 33
Appendix 3: Genogram 36
Appendix 4: Summary of Events 37
Appendix 5: References & Bibliography 38

EXECUTIVE SUMMARY

Alberta's Office of the Child and Youth Advocate (the "Advocate") is an independent office reporting directly to the Legislature of Alberta, deriving its authority from the *Child and Youth Advocate Act*. One role of the Advocate is to "investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest".

In the summer of 2012, Kamil (not his real name)[1], a 17-year-old youth was found deceased in the home he shared with his eldest sister. He had taken his own life. At the time of his death, Kamil was the subject of a Permanent Guardianship Order. In November 2012, the Advocate advised the Minister of Human Services that an Investigative Review into the circumstances of Kamil's death would be conducted.

Kamil was of Middle-Eastern descent and immigrated to Canada along with his two sisters when he was 12 years old. Less than a year after their arrival, the children were brought into the care of the Director[2]. In the four short years he was in care, Kamil had six different caseworkers and a series of placements resulting in ten moves. His behavior could be volatile and he suffered from mental health issues. Significant language and cultural barriers contributed to a very difficult situation for him and those who supported him.

By most accounts, Kamil was a young man who was adjusting to a new life in Canada while struggling with traumas from his past. The supports received by a foster parent, a school principal and a caseworker provided him with a degree of relationship stability for a period of time. One person stated, "Kamil had a lot of love in him".

The information gathered through the investigative process revealed a number of key issues related to practices and processes in the child intervention system:

- **Understanding the Cultural Context.** Kamil clearly struggled with strong and often conflicting cultural dynamics in his life and in his community. An understanding of his pre-migration and post-migration experiences and engaging family or community members could have shed some light on his life and experiences. This kind of cultural awareness is vital for assisting children and youth as each young person will have a unique life history. Developing a comprehensive cultural context will therefore be important for identifying appropriate resources that are accessible to assist young people.
- **Building Protective Factors in Children and Youth.** An important aspect of Kamil's situation was how decisions were made largely based on incidents or crises without

[1] All names used throughout this Investigative Review are pseudonyms. Section 15(3) of the *Child and Youth Advocate Act* states that a report must not disclose the name of, or any identifying information about, the child to whom the investigation relates or a parent or guardian of the child.

[2] Care of the Director refers to the Director as per the *Child, Youth and Family Enhancement Act*

due consideration for fully understanding his history and life experiences. The child intervention system seems to exist in a reactive mode, with insufficient time spent on proactive treatment and assistance. By assessing the child's protective factors and proactively building on them, the system can meaningfully improve a young person's resiliency and well-being.

- **Managing Medication for Mental Health Diagnoses.** Kamil's situation raises serious concerns about the ways in which the child intervention system approves and monitors the use of medications for young people with mental health diagnoses While Kamil's own reticence to consistently take his medication and his use of street drugs, no doubt hampered his progress, the system generated roadblocks and confusion that undermined the consistency of his mental health treatment. There is a need for better integration between the child intervention system and the health system to fully understand a young person's diagnosis, treatment options and to provide the necessary treatment.
- **Enhancing the Quality of Decision-Making.** Many of the Advocate's findings and recommendations in this review point to a broader issue about the ways in which decisions are made in the child intervention system. It is clear that caseworkers tried to deliver appropriate supports and services to Kamil in the face of difficult circumstances. The Ministry of Human Services needs to ensure the provinces' child intervention system is one in which children and youth receive consistent quality care no matter where they live, where they come from or the difficult circumstances they are in.

To address these issues and to help improve the effectiveness of Alberta's child intervention system, the Advocate makes the following five recommendations:

1. Assessments should be undertaken with and informed by a comprehensive understanding of a young person's cultural context, including their life history, background and relationships (both pre and post migration), to improve the effectiveness of intervention services.
2. The child intervention system should assess each young person holistically, including identification and assessment of their protective factors, and work proactively with community partners to maintain and strengthen these factors to improve the young person's resiliency and well-being.
3. The policy regarding approval of psychotropic medications should be amended to recognize and reflect the urgency of situations in which young people are prescribed these medications. And there should be a requirement to communicate back to the mental health professional(s) when a recommended medication or therapy is not approved.
4. Caseworkers should personally communicate with young people and their mental health providers to obtain thorough and accurate information to ensure that their client's needs and interests are met.
5. Human Services should increase opportunities for Child Intervention staff to work in a more innovative, inclusive and collaborative environment to improve the quality of decision making for vulnerable children and youth.

INTRODUCTION

The Office of the Child and Youth Advocate

Alberta's Office of the Child and Youth Advocate (the "Advocate") is an independent office reporting directly to the Legislature of Alberta. The Advocate derives its authority from the Child and Youth Advocate Act,[3] which came into force on April 1, 2012. Prior to this legislation, the Child and Youth Advocate reported to the Minister of Human Services.

The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the Child, Youth and Family Enhancement Act[4] (the "Enhancement Act"), the Protection of Sexually Exploited Children Act[5] (PSECA) or from the Youth Criminal Justice System.

Investigative Reviews

Section 9(2)(b) of the Child and Youth Advocate Act provides the Advocate with the authority to "investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest".

Upon completion of an investigation under this section, the Advocate releases a public Investigative Review report. The purpose of an Investigative Review is to make findings regarding the services that were provided to the young person, and make recommendations that may help prevent similar incidents from occurring in the future.

An Investigative Review does not assign legal responsibilities, nor does it supplant or abrogate other processes that may occur, such as investigations or prosecutions under the Criminal Code of Canada. The intent of an Investigative Review is not to find fault with specific individuals, but to identify key issues along with meaningful recommendations which are prepared in such a way that they address the systemic issue(s), are specific enough that progress made on recommendations can be evaluated; yet, not so prescriptive to direct the practice of Ministries. It is expected that the Ministries will take careful consideration of the recommendations, plan and manage their implementation along with existing service responsibilities. The Advocate provides an external review and advocates for system improvements that will help enhance the overall safety and well-being of children who are receiving designated services. Fundamentally, an Investigative Review is about learning lessons, rather than assigning blame.

---

[3] *Child and Youth Advocate Act*, S.A. 2011, c. C-11.5.

[4] *Child, Youth and Family Enhancement Act*, RSA 2000, c. C-12.

[5] *Protection of Sexually Exploited Children Act*, RSA 2000, c. P-30.3.

About This Review

In the summer of 2012, Kamil (not his real name),[6] a 17-year-old youth, was found deceased in the home he shared with his eldest sister. The Office of the Medical Examiner determined Kamil's manner of death to be suicide by hanging. At the time of his death, Kamil was the subject of a Permanent Guardianship Order.

The Advocate thoroughly reviewed file information provided by the Ministry of Human Services, which identified a number of potential systemic issues that would benefit from an Investigative Review. In November 2012, the Office of the Child and Youth Advocate advised the Minister of Human Services that an Investigative Review into the circumstances of Kamil's death would be conducted.

The Office of the Child and Youth Advocate attempted to contact members of Kamil's extended family, to notify them of the Investigative Review and give them an opportunity to provide input into the review. However, the OCYA was not successful in contacting family members.

Terms of Reference for the Investigative Review were established, a copy of which is provided in Appendix 1. An investigative team was assigned to gather information and conduct an analysis of Kamil's circumstances through a review of relevant documentation, interviews and research. Child intervention staff, mental health professionals, school staff and caregivers were interviewed who were able to provide a "picture" of who Kamil was and answer questions that had arisen through the review of file information[7].

A preliminary report was then completed that was presented to a committee of subject matter experts whose purpose was to provide advice related to findings and recommendations. A list of committee members is provided in Appendix 2. Committee membership was determined based on members' expertise in the areas of traumatized youth, immigrant children, forensic psychiatry and investigative death reviews.

[6] All names used throughout this Investigative Review are pseudonyms. Section 15(3) of the *Child and Youth Advocate Act* states that a report must not disclose the name of, or any identifying information about, the child to whom the investigation relates or a parent or guardian of the child.

[7] Individuals under the age of 18, who may have been able to provide additional information, were not interviewed

BACKGROUND

About Kamil

Kamil immigrated to Canada at 12 years of age. He was described as loving, playful and energetic, with a good sense of humor. Kamil found joy in things that others took for granted, and those who knew him took pleasure in seeing him do this. Kamil enjoyed the physical safety of Canada, which was far from the violence he had witnessed and endured in his home country in the Middle East.

Kamil struggled with school work. However, his work placement in a hair salon was positive and he felt a sense of accomplishment from this work. The salon was operated by individuals from his ethnic culture, whom he could identify with and talk with in his native language. Kamil struggled with the English language and often used humour as a way of deflecting his lack of understanding of the nuances of English.

He had a great deal of pride in his traditional culture, and at the same time took pride in becoming a Canadian. His role as the only male in his family and the differing expectations of his native culture and Western culture caused anxiety and confusion for him. He often felt frustrated and that things were beyond his control. When these feelings arose, Kamil could be volatile and destructive. While he could be quick to anger, Kamil was just as quick to apologize after a situation passed. He was also known to use street drugs such as marijuana.

Kamil had a number of adults in his life who were committed to assisting him to succeed, supporting him through his struggles, and accepting him for who he was. One person stated, "Kamil had a lot of love in him".

About Kamil's Family

Kamil was the middle child of a sibling group of three. He was of Middle-Eastern descent and immigrated to Canada along with his sisters when he was 12 years old. Prior to moving to Canada, a relative who already resided in Canada, adopted Kamil, his older sister Dinah and his younger sister Jale. The children had been living with their paternal grandmother, Halil, from a very young age since their parents were divorced. The children's mother had only sporadic contact with them as she was estranged from the paternal side of the family. Halil immigrated to Canada shortly after the children.

HISTORY OF INVOLVEMENT WITH CHILD INTERVENTION SERVICES

Overview

Less than a year after their arrival in Canada, Kamil and his siblings were brought into the care of the Director[8] and subsequently became the subjects of Permanent Guardianship Orders[9]. Kamil had a series of placements in foster care, kinship care, group care, residential treatment, independent living and supported independent living. He lived with his older sister in a supported independent living situation during the final year of his life.

Services Provided to Kamil at 13 Years Old

Kamil and his sisters came to the attention of Child Intervention Services within the first year of their arrival in Canada. This happened when Kamil's older sister, Dinah, disclosed that she had been sexually abused by a relative.

As a result of the disclosure, the children were placed under emergency care[10] with family friends and subsequently apprehended[11]. They were moved temporarily to a foster home while their family friends completed an application to become an approved kinship care placement for them.

The relative was charged with sexual interference but found not guilty. It took over two years for the court process to conclude. The accused relative felt the allegations brought shame to his reputation and family.

Caseworkers and care providers were concerned for the children's safety, as many members of the local ethnic community supported the relative and made threats towards Dinah and Kamil. Additional supports were provided to care providers as a result of these threats and intimidation.

---

[8] Care of the Director refers to the Director as per the *Child, Youth and Family Enhancement Act*

[9] Under a Permanent Guardianship Order, the court awards guardianship of the child to the Director on a permanent basis. The child is in care of the Director and remains in an approved placement. The guardianship of any former guardian is terminated and the Director is made the sole legal guardian of the child.

[10] Emergency care is sought if the director is satisfied that without the provision of emergency care a child may be in need of intervention because the guardian cannot be located, has died or become incapacitated the director may convey the child for the purpose of placing the child. The person, who is known to the children, may care for the child not more than 10 days.

[11] An Apprehension Order is sought when a child cannot be adequately protected in their family setting. The court grants the Director temporary custody and guardianship of the child. Guardianship is shared with child's parent/legal guardian. The child is placed in an approved placement.

Two months after the apprehension, Caseworker One[12] pursued a Permanent Guardianship Order, as it was felt unlikely that they would be safe in their relative's care.

The kinship family requested that an alternate placement be found for Kamil. They found that he was assuming a domineering role towards his younger sister Jale. Kamil was described as physically and verbally aggressive towards Jale. It appeared that he struggled to reconcile his new role as a child in a kinship family with what he saw as his traditional gender role as the male head of his biological family.

Due to ongoing safety concerns related to threats from some members of the ethnic community, Jale and Dinah were moved to a distant community. They were placed together in a foster home, while Kamil was placed in a separate foster care arrangement. Through the use of the internet, he reconnected with relatives in his home country. He reported receiving threatening messages from relatives because he was supportive of his older sister. The emails were deleted before they could be verified by Caseworker One. Kamil's medical report indicated that he suffered from fear and anxiety.

A family support worker was engaged to supervise visits between the children and provide support to their foster families. The children were involved with activities supporting adjustment to Canadian culture and preserving their traditional culture. Safety planning was reviewed so that the children would know what to do in situations where they did not feel safe.

Although Kamil could speak English, he had difficulty understanding abstract concepts. He became frustrated at school, which manifested in aggressive outbursts and resulted in several suspensions. Caseworker Two, the foster parent, the foster care support worker, and the family support worker, along with school staff, identified and coordinated supports for Kamil, including mental health counselling. An academic assessment was subsequently completed and his school program was modified.

Kamil was mostly compliant at the foster home. However, after being there for approximately three months he calmly threatened to kill his foster mother if he had to stay at home to complete school work during school suspensions. The threat was taken seriously and he was moved to a staffed group home outside the community.

During Kamil's first two weeks at the group home, staff at the home received phone calls from men claiming to be Kamil's relatives and making threats against him. The police were contacted and a safety plan was implemented.

A psychiatric assessment concluded that Kamil had done extremely well given the major adjustments and considerable pressures he faced during the past year. It was likely that his anger, behavioral outbursts and nightmares represented a fear-based type

[12] At the time of involvement with Kamil, Caseworker One, Two, Three and Four were assigned to the same office.

of Post-Traumatic Stress Disorder (PTSD)[13]. The psychiatrist recommended counselling with a counsellor familiar with PTSD, increased contact with his sisters, consultation with a trusted cultural representative, and a youth worker. He was prescribed Zoloft[14] to control his anxiety.

Group home staff described Kamil as polite, respectful and affectionate. However, when he became angry he would damage property and threaten staff. He was charged after several incidents of property damage and required to complete community service hours. He spoke of the severe violence he witnessed while in his home country. Staff members felt that Kamil was confused about the two very different cultures, specifically related to gender roles.

Over the next several months Kamil's sleep patterns, energy level and behaviour improved and his medication was discontinued. He continued to have supervised visits with his sisters while he was in the group home and he requested involvement with his ethnic community.

Kamil's sisters were moved to a new foster home due to ongoing safety concerns related to ongoing threats received from some members of the ethnic community. As a result, the family support worker terminated her involvement, since the children were all placed outside of her service area.

Services Provided to Kamil at 14 Years Old

A Permanent Guardianship Order was granted during the month following Kamil's fourteenth birthday. Halil (paternal grandmother) was to have visitation and access at the request of the children. Initially, the children did not want contact and refused her letters. Kamil vacillated between wanting contact with his grandmother and not wanting contact with her.

Kamil was discharged from the group home and placed with his sisters in their foster home. Shortly after his placement, difficulties arose as he challenged the foster parents' "parenting authority". Due to Kamil's cultural upbringing he felt that his role was to be the parent to his sisters. Within a month after his placement, he punched his foster father during a heated discussion and was subsequently moved to Mrs. White's[15] foster home.

---

[13] PTSD is an anxiety disorder that may develop following an individual's experience or witnessing serious harm or death. Although no longer in danger, the individual may feel intense fear or stress. Symptoms include flashbacks or bad dreams, emotional numbness, intense guilt or worry, angry outbursts or avoiding thoughts and situations that remind them of the trauma

[14] Zoloft is an antidepressant used to treat depression, obsessive-compulsive disorder, panic disorder, anxiety disorders, and post-traumatic stress disorder

[15] Mrs. White was the foster parent who provided Kamil with the most consistent and long term placement during his child intervention involvement

Although Mrs. White believed Kamil's placement was to be short term, he spent a total of 29 months in her home. Several interviewees described Mrs. White as having a strong, supportive connection with him. She was a strong advocate for Kamil and proactive in locating services and supports for him. She worked well with service providers and the school.

Another young man, Jack, also resided in the foster home throughout Kamil's placement. Kamil preferred to share a room with Jack because he did not like to be alone in the dark. He continued to suffer from nightmares.

Mrs. White worked with the school to arrange counselling and a "Success Plan" for Kamil since he continued to struggle with academics. His school program was modified, allowing him to attend half-day classes and work for the remainder of the day.

His foster mother was aware that culture was important to Kamil so she connected him with people who shared his cultural background and religious beliefs. He was provided with a role model and had the opportunity to speak his language and share cultural memories. They went to places where Kamil could shop in ethnic stores. A place of worship was available in the community, but he expressed uncertainty about whether he wanted to attend.

Kamil looked forward to visits with his sisters, but he was often left frustrated when he did not like the way his sisters dressed or when they disagreed with him. He remained indecisive about whether he wanted visits with his grandmother. He was still fearful that a relative could harm him or his sisters. An Emergency Protection Order was obtained prohibiting the relative from contacting Kamil.

Mrs. White stated that she and Kamil were frustrated with the communication struggles they encountered involving Caseworker Three. She said that several months went by without a face-to-face meeting. She believed that Kamil wanted to develop a relationship with his caseworker, as opposed to contact being limited to email and phone calls.

File documentation was not always clear in identifying the frequency or details of face-to-face contacts between the caseworker, Kamil and Mrs. White.

Kamil continued to struggle with memories of his past and his current situation. Mrs. White reported that he told her he would "rather be dead than do this anymore". Kamil was subsequently taken to the hospital for a suicide assessment. The assessment concluded he was at low risk for suicide and he was discharged.

Kamil associated with a negative peer group and there were concerns regarding marijuana use, drinking and fire-setting. He was suspended from school for swearing and property damage. He exhibited a defiant attitude and was verbally aggressive toward his foster mother. At one point a request by Mrs. White for respite was approved; however she was required to locate her own resources. She enlisted her daughter, who lived several hours away, since the daughter had a positive relationship with Kamil.

Mrs. White emailed Caseworker Three regarding Kamil accessing the mental health walk-in clinic, and requested that arrangements be made for him to reconnect with his previous psychiatrist. The caseworker agreed to make the arrangements but before she could follow up, Kamil fell unconscious after he used illicit drugs. Mrs. White requested that he be held for a complete mental health assessment at the hospital. The emergency room physician saw no reason to admit him and recommended that Kamil attend the mental health walk-in clinic.

Mrs. White was very concerned about Kamil's escalating behaviors and emailed Caseworker Three that it was imperative they meet to develop a plan for services. The caseworker replied that she was looking into a referral to Dr. Aaron, a child and adolescent psychiatrist. Meanwhile, Mrs. White took Kamil to the outpatient clinic where the hospital physician facilitated an appointment with Dr. Aaron. Due to his escalating behaviours, Kamil spent four respite days at a nearby residential facility. However, this did not improve his behaviours when he returned to the foster home.

Mrs. White contacted the Crisis Unit several times to report critical incidents involving Kamil punching himself, running away, fire setting, stealing her truck and threatening suicide. On two occasions, he was taken to hospital for assessment after he threatened suicide. During one incident, he had to be restrained by two police officers when he tried to take one officer's gun so that he could shoot himself. He continued to fight even while under restraints at the hospital. The physician administered Ativan[16] to calm him. When Kamil still was not calm, Zyprexa[17] was administered.

Kamil was transported to a larger hospital that had appropriate facilities to assess his needs. A psychiatric assessment was completed and it was determined that he was likely affected by PTSD. He was prescribed Seroquel[18]. A regional manager provided consent for this prescription.

Kamil was subsequently placed at the nearby residential facility while additional mental health assessments were completed with the hope of admitting him to a four-month in-house program in another area of the province.

[16] Ativan affects chemicals in the brain that may become unbalanced and cause anxiety. Ativan is used to treat anxiety disorders

[17] Zyprexa is an atypical antipsychotic medication. It is used to treat the symptoms of psychotic conditions such as schizophrenia and manic depression in adults and children who are at least 13 years old

[18] Seroquel is an antipsychotic medicine. It works by changing the actions of chemicals in the brain. It is used to treat schizophrenia and bipolar disorder (manic depression).

Services Provided to Kamil at 15 Years Old

Kamil resided at the residential facility for two and a half months. There were 17 Incident Reports where he left without permission during the first 23 days of his stay. On some occasions, he returned under the influence of drugs but more often he was compliant and not under the influence. He often missed his evening dose of medication, either because he left the facility or refused to take the medication. Police responded to several incidents involving Kamil threatening staff or threatening to kill himself.

Mrs. White maintained contact with him during his placement at the residential facility. She took him to appointments with his mental health therapist, who was approximately 100 kilometres away, and she facilitated sibling visits whenever possible.

Kamil told Dr. Aaron that he experienced panic attacks, nightmares, flashbacks and blacking out. He described his mood as mostly happy but that he sometimes felt suicidal. Dr. Aaron diagnosed Developmental Trauma Disorder[19], PTSD, Conduct Disorder[20], substance abuse of nicotine and marijuana, and symptoms of Bipolar Disorder. Dr. Aaron changed Kamil's medication to Risperdal[21] when he determined that Kamil was not tolerating Seroquel. He also recommended one-on-one counselling and addictions support which were implemented while Kamil was at the residential facility. Counselling sessions were not successful in deterring him from smoking cigarettes or using marijuana.

Within a few days of Dr. Aaron prescribing Risperdal, Kamil saw his family doctor (Dr. Lang), who confirmed that Kamil was physically healthy. Dr. Lang prescribed Seroquel due to his anxiety and stress.

Neither the prescription for Risperdal nor the prescription for Seroquel was filled. Through the investigative review it was determined that both prescriptions were made shortly after Kamil was admitted to the residential facility and staff were unsure which prescription to fill. Child intervention services did not provide approval for either medication.

Kamil was fearful of the dark and continued to have nightmares. There were several occasions where he felt a shortness of breath and was treated at the hospital. Medical staff attributed the shortness of breath to anxiety attacks. The attacks sometimes coincided with sibling visits or therapy appointments.

---

[19] Developmental Trauma Disorder incorporates threads from Reactive Attachment Disorder, Oppositional Defiant Disorder, AHD, PTSD and provides a comprehensive view of behaviors of children who have experienced trauma during their early lives.

[20] Conduct Disorder is characterized by behavior that violates either the rights of others or major societal norms. To be diagnosed with conduct disorder, the symptoms must cause significant impairment in social, academic or occupational functioning.

[21] Risperdal is used to treat schizophrenia and symptoms of bipolar disorder (manic depression).

Kamil and Dinah were observed bullying Jale during sibling visits and speaking their native language. This caused Jale to become very upset. Caseworker Three had difficulty finding an interpreter, so the children were required to speak English during visits. Through the investigative review, Mrs. White advised that she had located an interpreter and provided the information to the caseworker but the interpreter was not utilized.

Kamil contacted the Office of the Child and Youth Advocate and requested assistance in addressing two concerns: potential placement at an in-house mental health program and not being permitted to speak his native language during sibling visits. Before an advocate could meet with him, his concerns were resolved.

Kamil returned to Mrs. White's foster home and a psychological educational assessment was completed. Testing indicated that he had an IQ of 66, which fell within the range of a "learning disability". However, the psychologist believed that the results might not be accurate due to the language barrier and Kamil's distraction during testing. Personality testing was consistent with substance abuse and signs of an emerging passive-aggressive personality. Recommendations included a psychiatric referral for medication, school modifications that included an English-as-a-Second-Language (ESL) resource, a highly structured environment, and counselling to address identity issues related to his immigrant/cultural status.

Modifications in his school program provided him the opportunity to work in a local hair salon while attending classes for half days. The hair salon was operated by members of his ethnic culture. Kamil was very pleased with this arrangement, however he was often absent from classes. The mental health therapist felt that Kamil required medication to support his focus at school. She noted that Dr. Aaron's recommendation for Risperdal three months prior had not been implemented. Kamil informed the therapist and Mrs. White that he did not want to take medication.

A new caseworker (Caseworker Four) was assigned and met with Mrs. White, Kamil and the foster care support worker. Kamil voiced concerns about his sisters, his lack of sleep and the change of therapists. During the meeting, the parties discussed strategies for dealing with his feelings and solutions to reduce stress. Mrs. White felt that he thrived on face-to-face contact with his caseworker and that emails and phone contact were not sufficient for him.

Some time later, Caseworker Four, Kamil, Mrs. White, the school principal, the mental health therapist, the foster care support worker and the foster care manager attended a case conference. Additional respite was approved for Mrs. White and Kamil's child intervention file was to be transferred to the office located closer to the foster home.

Four months after Kamil's return to Mrs. White's foster home, reports from the school, mental health therapist and Mrs. White indicated that Kamil was doing better. He was described as polite and helpful with a positive attitude. He attended school regularly

while working part-time and his marks improved. The principal reported that Kamil was good at accessing school counselling services when he needed to talk to someone. He enjoyed being on the school football team and he had friends.

Kamil told Caseworker Four that he was generally happy. He believed he did not need to see the mental health therapist and began to attend fewer therapy appointments. He was still using marijuana and had the occasional verbal outburst, but he had a strong desire to succeed and finish school.

Further, he told his caseworker and Mrs. White that he found it frustrating that his visits with his sisters were supervised, that their conversations were monitored and that they were still not permitted to speak their native language with each other. Arrangements were made for the children to attend counselling to work through their issues and improve their relationships.

During this time, Kamil's older sister, Dinah, required a placement and requested that she be placed with Kamil. Mrs. White agreed to Dinah moving into the home.

Through the investigative review, Mrs. White advised that, in her opinion, Kamil's anxiety increased and he lost confidence after Dinah was placed in her home. Kamil also became involved with a negative peer group. He skipped classes and had difficulty controlling angry outbursts at school and at home. He was suspended from school and quit his part-time job.

Kamil was increasingly more defiant and verbally abusive; however he would typically apologize for his behaviour afterwards. Mrs. White requested that the mental health therapist become involved again and indicated that she needed more supports, including additional respite. She was directed to discuss this with the new caseworker (Caseworker Five) as the file was to be transferred to an office near her home.

Services Provided to Kamil at 16 Years Old

Caseworker Five had frequent contact with Kamil and described him as mostly happy and excited about life, but that he experienced highs and lows. Kamil was loyal, charismatic and funny; he was concerned about everyone including his caseworker. He was a good advocate for himself.

Within two weeks of the file being transferred to her, Caseworker Five held a case conference attended by Kamil, Mrs. White, the site manager, and an Outcome Based Service Delivery (OBSD)[22] family support worker. Additional respite was approved for Mrs. White. The family support worker was to contact mental health services to arrange appointments and educational testing for Kamil in his native language.

[22] Outcome Based Service Delivery (OBSD) focuses on the child and the family within their schools and community to work towards positive changes. OBSD agency workers work collaboratively with professionals and agencies to improve effectiveness of services and reduce any potential gaps or repetition.

Kamil met with the mental health therapist and requested medication to help reduce his anxiety. A conference was held with Dr. Aaron, who had not seen him for approximately ten months. Dr. Aaron was concerned that Kamil had the same symptoms as when he had first been examined. Further, Dr. Aaron expressed concern regarding Child Intervention Services' failure to approve Risperdal. Dr. Aaron believed that if Kamil was not medicated then he was at risk of harming himself or others. Caseworker Five forwarded a medication consent form to the appropriate manager and received approval to fill the prescription. Dr. Aaron and Mrs. White noted improvement in Kamil's behaviour when he started taking Risperdal.

Kamil told Caseworker Five that Dinah had advised him not to take the medication, but that he found it helpful. He felt that his weekly meetings with the mental health therapist were going well. He was stressed about arguments he had with Jack (who also lived in the foster home) because Jack made disrespectful remarks about Dinah. Kamil said that he loved Mrs. White but that he wanted to move in with Dinah when she turned 18 years old. Mrs. White was willing to have Dinah stay in the foster home after Dinah's eighteenth birthday.

Mrs. White expressed concerns about Dinah to Caseworker Five, which included concerns about her influence over Kamil. Dinah had convinced him to stop taking his medication and was encouraging him to move out with her. Subsequently, there was a confrontation while Dinah was packing her belongings because Kamil wanted to go with her, which resulted in a call to the Crisis Unit. Mrs. White did not feel safe and Kamil was moved to a respite home. Dinah moved to her boyfriend's apartment.

A few days later, he returned to the foster home. His foster mother was willing to accept him back as he was no longer angry and he was willing to take his medication.

Dinah had made several allegations regarding Mrs. White and what was happening in the foster home, including an allegation about inadequate supervision. An assessor (Assessor Two) was assigned to conduct an investigation into the foster home. She met with Kamil regarding the allegations and completed a risk assessment with him. It was determined that he was at risk for harming himself. He was taken to the hospital where he met with Caseworker Five, Dr. Aaron, and two mental health therapists.

Dr. Aaron emphasized to Kamil the importance of taking Risperdal regularly and abstaining from drugs or alcohol. The mental health therapists confirmed a schedule of therapy appointments and a safety plan was developed.

Kamil did not return to Mrs. White's foster home after his appointment. He and Dinah were strongly advocating for placement together. Caseworker Five believed that if he was not allowed to stay with his sister then he would run away. Kamil was placed with Dinah and her boyfriend in a supported independent living arrangement.

During the Investigative Review, Mrs. White reported that after Kamil moved out of her home, individuals known to be involved with drugs, started phoning and appearing at her home asking for Kamil. She had no further contact with Kamil.

Caseworker Five increased contact with Kamil after his move. He indicated that he felt supported by her and thanked her for being there for him. Caseworker Five regularly accompanied Kamil to medical appointments. Despite the additional support, he continued to have difficulty following through with agreed-upon plans such as attending therapy and school.

Kamil's move in with Dinah coincided with the beginning of a new school semester. Although an alternative school program was provided and the school went to extraordinary lengths to enable his success, he missed many classes.

Caseworker Five found it was becoming more difficult to provide services to Kamil. Around this time she met him at the apartment for the last time (seven months prior to his death). Subsequent meetings were held elsewhere. He told her that he was using marijuana almost every night and that he had been smoking it while living with Mrs. White. He had not taken any medication for a few weeks because his prescription needed to be refilled.

Caseworker Five arranged for the Risperdal to be refilled and for appointments with the mental health therapist twice per week. Kamil failed to show up for the appointments. Mental health services kept his file open for four months due to concerns about his impulsive behaviour, mood swings characteristic of bipolar disorder, and PTSD.

Kamil contacted Caseworker Five when he found a job in a warehouse and quit school. He felt things were going well and he did not require counseling. He wanted to put school on hold and work for the remainder of the school year. While not wanting to attend therapy, Kamil was willing to accompany Caseworker Five to the walk-in clinic once a week. He indicated that he liked living with Dinah and her boyfriend. However, he did not tell his caseworker that he had approached the police on several occasions because he was worried for his safety and threats he had received related to the drug trade.

Visits between Kamil, Dinah and Jale were put on hold for four months after Dinah was charged with threatening to burn down Jale's foster home. Kamil was angry at Jale for informing authorities about the threats and he was angry with Dinah for making the threats.

Services Provided to Kamil at 17 Years Old

Shortly after Kamil's 17th birthday, Caseworker Six started working with Kamil. He continued to require lots of support to attend appointments; he was resistant to counseling and he quit his job.

Caseworker Six met with Kamil on two occasions during the month that she was his caseworker. On the first occasion, Kamil said that he felt like he was going to blow up one day, but added that he was not stupid enough to blow up and that he could keep himself calm. The caseworker suggested that a youth worker might be helpful, but Kamil was resistant and preferred to be reconnected with mental health services.

Services Provided to Kamil the Day Before His Death

Kamil contacted the office, he was very upset, crying and shouting that someone needed to pick him up immediately from his sister's apartment. He and his sister had argued, resulting in damage to the home including a broken window, holes in the walls and a destroyed television. It was not clear what had sparked the argument. He said that he was going to kill himself. When he was advised that his caseworker would pick him up, Kamil calmed down.

Kamil met Caseworker Six in front of the apartment building with his duffle bag. He stated that he had taken 15 Risperdal pills but that he refused to go to a hospital. He said that Dinah broke his heart and the only reason he had been living with her was to protect her from their relatives. He wanted to go to a foster home or residential facility for a few days until he found his own place. The caseworker took Kamil back to her office to speak with her supervisor. By the time they arrived at the office, Kamil was calmer.

The supervisor wanted Kamil to go to the hospital because of the number of pills he had ingested, but he refused to go. It had been several hours since he had reported that he had taken the medication. His appearance and behaviour were normal and he did not appear to be under the influence of any medication. It appeared that he had not been telling the truth about taking the pills, so the supervisor did not insist on medical follow up.

The supervisor agreed to look at independent living for him; however, Kamil required a place to stay that evening. He rejected a placement at the youth shelter and could not locate friends to stay with overnight. The supervisor spoke with Dinah who said she was not having her brother back to live with her. Kamil apologized to Dinah over the phone and Dinah eventually agreed to have him back until other plans could be made.

A Safety Plan was discussed with Kamil. He was provided with the Crisis Unit telephone number in case things again escalated. He agreed to not take any pills and gave his word that he would not do or say anything to Dinah. He was joking and in a good mood when he left the office.

Caseworker Six dropped Kamil off in front of the apartment building. He said that he was looking forward to getting his own place. They agreed to meet the next day and discuss plans, including a more permanent living arrangement.

Early the next morning, Dinah contacted the Crisis Unit stating that she had just arrived home and found Kamil deceased on the bathroom floor. The duty worker met the police at the apartment. The apartment was described as a health concern due to uninhabitable living conditions. Caseworker Six was notified of Kamil's death and informed Jale. At Jale's request, she was allowed to inform their relatives about

Kamil's death. The supervisor indicated that, due to confidentiality, others who had relationships with Kamil were not contacted. Mrs. White, Jack, the school principal and mental health services became aware of his passing through social media.

Police investigated the circumstances around Kamil's death and found that it was non-criminal. An autopsy was performed and the Medical Examiner ruled the cause of death to be suicide. A toxicology report found a small amount of cocaine in Kamil's system.

DISCUSSION AND RECOMMENDATIONS

The information gathered through the investigative process revealed a number of key issues related to practices and processes in the child intervention system:

- Understanding the cultural context;
- Building protective factors in children and youth;
- Managing medication for mental health;
- Enhancing the quality of decision-making.

An analysis of these issues has revealed some systemic challenges. The goal is to learn from these, in order to prevent similar tragedies such as Kamil's from occurring and to enhance the overall effectiveness of the child intervention system. Each key issue, along with recommendations follows.

Understanding the Cultural Context

Culture is a critical part of the overall landscape when delivering intervention services and assisting children and youth. A young person's sense of identity is developed and maintained through connections with their culture. Culture also influences how a young person experiences and interprets the world around them, and can have profound effects on their emotional and spiritual development. As the Advocate has noted before, the concept of culture is complex and value-laden. Consequently, it is important that professionals who are working with children and youth — in the child intervention system, criminal justice system, health system, education system and other systems — have as full an understanding as possible of the cultural context at play.

In this situation, the cultural context was not as well understood as it could have been. Kamil clearly struggled with strong and often conflicting cultural dynamics in his life and in his community. The nature of these struggles and the root reasons for them were not clear to the individuals and systems that worked to provide assistance to Kamil. This is because information was lacking in a number of areas, especially with respect to his life prior to arriving in Canada. It would have been helpful for those assisting Kamil to better understand both his pre-migration and post-migration experiences. For example:

- What was Kamil's home life like in his country of origin?
- How did his family of origin handle issues and disagreements?
- What type of violence did Kamil and his sisters witness and experience in their country of origin?
- What kind of traumas did they experience in that country?
- How did Kamil's family in his home country respond to issues they experienced?
- What was Kamil's role in the family in his home country? For example, whether he was the only son, and/or whether he had assumed other roles during his time there.
- Were there other supports available to Kamil in his country or origin, or in Canada?

Child intervention workers could have engaged members of Kamil's family in Canada to gain better insight into the background of Kamil and his sisters. In the event there was no practical way to engage these sources, other members of the local ethnic community could have been engaged. It is possible one or several members of the community could have shed some light on Kamil's life and experiences before his immigration to Canada.

Instead, the choices made by the child intervention system in the wake of Dinah's sexual assault allegations effectively cut Kamil off from his cultural community. The system later made further choices that compounded the isolation from the local ethnic community, making it that much harder to gather valuable information. This is extremely unfortunate, because such information would have provided a more

thorough understanding of the cultural context and a more complete picture about what was happening in Kamil's life. This would have better illuminated the sources of Kamil's struggles, and better informed the choices made in the delivery of intervention services.

With a limited understanding of the cultural context, people who were delivering services to Kamil may have felt they were doing the right thing, but in fact were exacerbating his internal conflicts. In response to present and perceived violence, Kamil was pulled away from his connections to his community, culture and language. For instance, caseworkers did not allow Kamil to speak his native language on visits with his siblings, out of concern for Kamil's younger sister, impairing his ability to express thoughts and emotions which may have led to anger and frustration. Various decisions were made about his contact with his older sister, but this relationship also touched on cultural differences leading to distress in Kamil. Different decisions might have been taken had there been a comprehensive understanding of the cultural context.

Mrs. White deserves recognition for the efforts she made to connect Kamil with his culture. She actively sought out cultural resources for Kamil, including an interpreter and mentors who shared his cultural background and religious beliefs. People noted that Kamil did well during periods in her foster home.

This kind of cultural awareness is vital for assisting children and youth in Alberta, and will be increasingly so in the years ahead. Levels of immigration to Alberta have been rising over time and this trend is expected to continue. As Alberta welcomes more families from all over the world, the child intervention system will be called upon to serve an increasingly diverse range of young people. Each young person will have a unique life history and will present with a unique cultural context.

Against this backdrop, there needs to be greater rigor in assessing young people so that intervention services are delivered within a comprehensive cultural context. Assessments of children and youth must be culturally informed. This requires meaningful investigation, sometimes using various pathways, to develop as complete a picture as possible of the young person's life history, background and relationships. The factors impacting a young person's development, before and after their migration to Alberta, need to be identified to better understand how intervention services should be delivered to the young person.

It is also important for the child intervention system to recognize there will be different levels of engagement from different cultural communities. While some will wish to be very involved in assisting young people, others will be more limited in their involvement. Developing a comprehensive cultural context will therefore also be important for identifying cultural resources that are accessible to assist a young person.

Recommendation #1

Assessments should be undertaken with and informed by a comprehensive understanding of a young person's cultural context, including their life history, background and relationships (both pre and post migration), to improve the effectiveness of intervention services.

Building Protective Factors in Children and Youth

An important aspect of Kamil's situation is how decisions made by child intervention services for him were largely based around incidents.

The chronology of events suggests that services were delivered in a very reactive mode, much like a trauma unit in a hospital emergency room. An incident or crisis involving Kamil would occur, and a decision would be made to address or manage around the immediate crisis. Once the crisis had passed and Kamil had a period of stabilization, the system "backed away" until another crisis emerged.

By contrast, a similar level of focus was not placed on learning more about Kamil's underlying trauma and challenges that were propelling him into incidents and crises. The violence threaded throughout his life was not examined or reviewed, but just attended to in moments of crisis. Kamil went from incident to incident and crisis to crisis, changing placements and caseworkers along the way, without an extended period of stability.

Regrettably, this happens in the child intervention system. The focus placed on addressing immediate crises crowds out the equally important focus of understanding a young person and providing supports that will enhance their development and well-being in enduring ways. The child intervention system tends to exist in a reactive mode, with insufficient time spent on proactive treatment and assistance. If positive outcomes for young people are to be achieved and improved upon over the long term, a different approach needs to be taken.

Certainly it is important for the child intervention system to address incidents and crises, so that young people are removed from harm's way and kept safe. Safety is a basic need. Children and youth need to be safe physically, psychologically and spiritually before their higher-level needs can be effectively addressed. Young people cannot develop to their full potential while they are fearful and focused on survival. However, once a crisis has passed and a young person is in a safe space, the child intervention system needs to look at and assist the young person in a holistic fashion.

Assessing a young person's risk factors is important, but this alone is insufficient and reactive for it focuses attention on the question of, "What possible crises is this young person at risk for and what can be done to mitigate them?" This approach has the system basically waiting for the next incident or crisis to inevitably occur. To look at the young person holistically, the system should also assess the young person's protective factors and proactively work to build these. Protective factors help enhance a young person's resiliency, enabling them to deal with challenges and circumstances they will encounter throughout their life. This includes factors such as:

- Positive self-esteem and peer relationships;
- Good coping skills;
- Family, community and cultural supports;
- Interest in and success at school;
- Healthy engagements with adults outside the home; and
- An ability to articulate feelings.

Each young person will present with certain protective factors to varying degrees, which can be leveraged and strengthened. Others will be minimal or absent, and the system should work with partners and community resources to build these protective factors. By working proactively in this fashion, the system can meaningfully improve the young person's resiliency and well-being, rather than responding reactively from incident to incident and crisis to crisis.

Recommendation #2

The child intervention system should assess each young person holistically, including identification and assessment of their protective factors, and work proactively with supportive adults to maintain and strengthen these factors to improve the young person's resiliency and well-being.

Managing Medication for Mental Health Diagnoses

Kamil's situation raises serious concerns about the ways in which the child intervention system approves and monitors the use of medications for young people with mental health diagnoses. While Kamil's own reticence to consistently take his medication, and his use of street drugs, no doubt hampered his progress, the system generated roadblocks and confusion that undermined the consistency of his mental health treatment.

At 13 years old, Kamil was prescribed Zoloft by a psychiatrist. After a number of months, this prescription was discontinued because he was sleeping better and his behaviours had stabilized. When Kamil was 14 years old, a physician prescribed Seroquel after a

crisis. There were no issues filling these prescriptions. Months later, when he was 15 years old, he regularly saw Dr. Aaron, who effectively served as Kamil's consistent mental health provider. Dr. Aaron changed Kamil's prescription from Seroquel to Risperdal. However, the request was not made within child intervention services to approve this prescription change, and the prescription was not filled. A few days later, Dr. Lang saw Kamil and prescribed Seroquel even though Dr. Aaron had determined that Kamil was not tolerating Seroquel. The approval for this prescription was also not requested and went unfilled.

Months later, both prescriptions remained unfilled and Kamil indicated that he did not wish to take medication, despite mental health providers suggesting he do so. When he was 16 years old, child intervention services approved the prescription for Risperdal, following a case conference in which Dr. Aaron expressed concern that if Kamil did not receive and take the medication he might harm himself or others. Following this and up until his death, Kamil's compliance with taking his medication and attending mental health appointments was sporadic at best. It was not evident through the Advocate's review whether he understood why he was prescribed medication, the importance of taking it consistently or the potential side effects.

It is critical that young people have a voice in decisions that affect them. They must understand why a medication or medical treatment is recommended. Child intervention workers need to work with mental health providers and engage with their young clients to ensure that young people are aware of the recommended treatment or medication, why it is recommended, potential side effects and any other information that might help the young person make a decision. Psychotropic drugs can be used to alleviate or lessen symptoms although they have also been criticized for their misuse and the side effects that some young people experience. This is reflected in the Enhancement Act Policy, section 9.1.2, which also requires that the Child and Youth Advocate be contacted if a child is not consenting; and, if the treatment is considered critical — a treatment order must be obtained if the child is over 12 years of age (or under 12 years and a mature minor).

Further, the approval process for psychotropic medications indicates that the consent of the Child and Family Services Authority (CFSA) Chief Executive Officer (CEO) or Delegated First Nation Agency (DFNA) Director or their designate "is required for a child in the care of the director...to receive medication that alters the mind, thought or behaviour..." As part of the process identified, a child intervention worker is expected to gather information (including obtaining a written recommendation) from the health professional about the proposed treatment. The worker then consults with their supervisor and manager regarding the treatment and ensures that the child is aware of what is being recommended and why. If the supervisor and manager are in agreement with the treatment, the consent of the CFSA CEO, DFNA Director or their designate is then sought. The process also identifies steps for when a child is not consenting and for when a child is over 12 years old and refusing treatment. A decision must be made within 10 working days.

The process for approval of psychotropic drugs can be lengthy. Obtaining the professional's written recommendation for treatment, consulting with the supervisor and manager and then awaiting the CEO's or DFNA Director's (or their designate's) consent can take up to two weeks. This means that a young person, assessed to be at risk of suicide, who requires a psychotropic drug might not get the treatment when they need it. Decisions about the use of these medications are critical and need to be made by child intervention services in a timely fashion.

The policy regarding approval for psychotropic medications (and other therapies) also needs to be clarified for those instances where recommended prescriptions or therapies are not requested and approved by intervention staff. In Kamil's situation, there was poor communication with the health professionals who had prescribed medications that were filled. This generated confusion and led to interruptions and inconsistencies in drug therapy for Kamil. Such a situation should not occur. A young person's underlying challenges or conditions do not cease to exist when child intervention staff deny a recommended medication or therapy. If a CFSA or DFNA is not prepared to approve a medication or therapy that has been recommended for a young person, then the CFSA or DFNA has a duty to notify the appropriate health professional(s) and seek other treatment approaches for the young person.

To facilitate continuity of mental health care, there should be established procedures for child intervention services to communicate directly back to prescribing health professionals when a decision has been made not to approve or proceed with a recommended medication or therapy. This way, the health professional can remain abreast of the young person's condition and make alternative treatment recommendations for the young person.

Recommendation #3

The policy regarding approval of psychotropic medications should be amended to recognize and reflect the urgency of situations in which young people require these medications. In addition, there should be a requirement to communicate back to the mental health professional(s) when a recommended medication or therapy is not approved.

There is also a need for better integration between the child intervention system and the health system. Specifically, there should be a strong and clear information link between child intervention services workers and the mental health professionals who are assisting children and youth in care. Direct contact would be preferable when communicating with professionals to ensure that caseworkers have a full understanding of the young person's circumstances, their prescribed medications and the reasons for those prescriptions. This also enables them to learn what kinds of therapeutic

interventions (such as community resources) could complement or serve as alternates to drug therapy. Further, this will assist caseworkers in providing as much information as possible to their young clients so that young people can make well informed decisions about their own treatment options.

Recommendation #4

Caseworkers should personally communicate with young people and their mental health providers to obtain thorough and accurate information to ensure that their client's needs and interests are met.

Enhancing the Quality of Decision-Making

Many of the Advocate's findings and recommendations in this review point to a broader issue about the ways in which decisions are made in the child intervention system. It is clear that child intervention workers were trying to deliver services to assist Kamil in the face of difficult circumstances. A significant language barrier, a lack of information and cultural barriers all contributed to a difficult situation. And, in the wake of threats received from the local ethnic community, workers may have been apprehensive about pressing members of that community for information about Kamil and his sisters, at the risk of causing further polarization.

In four short years, Kamil had six different caseworkers, some who were very involved, and others who were not. He also moved ten times. Kamil, separated from his family and his community, was offered little continuity through his child intervention involvement.

The Ministry of Human Services needs to ensure the province's child intervention system is one in which children and youth receive consistent quality care, no matter where they live, where they come from or the difficult circumstances they are in.

What is most essential is that the right organizational culture be in place throughout Alberta's child intervention system. To meaningfully improve outcomes for children and youth in Alberta, the system must support, encourage and require its workforce to be more:

- curious and inquisitive, in which workers are always striving to obtain a more complete picture of a young person's life and circumstances;
- proactive in its thinking, such that it not only responds to risks but actively works to build resiliency in the children and youth it services;
- open and collaborative, with a willingness to partner and share information with other systems with the goal of improving a young person's overall life;

- team-oriented, with regions acting collectively as one system, and reaching out to each other beyond their boundaries with a spirit of cooperation; and
- self-aware, with workers willing and encouraged to identify and admit the limitations of their knowledge, and to reach out for assistance in those situations.

With this type of organizational culture in the child intervention system, the quality of decision making would have been better, resulting in improved services for Kamil and his family. Kamil's experiences may have been much different. A more complete picture of Kamil's life history, background and circumstances may have emerged, enabling more effective delivery of intervention services. People may have had a greater understanding of the cultural context, having benefited from reaching out to a wider array of knowledge resources. Members of Kamil's cultural community may have been better engaged to assist him, with the experiences of other regions being leveraged to overcome any prevailing fear and conflict in the community.

In the Advocate's opinion, an environment that fosters a curious and inquisitive, proactive and collaborative culture where innovative thinking becomes the norm would ultimately result in better services and supports to vulnerable children and youth in Alberta.

Recommendation #5

Human Services should increase opportunities for child intervention staff to work in a more innovative, inclusive and collaborative environment to improve the quality of decision making for vulnerable children and youth.

CLOSING REMARKS FROM THE ADVOCATE

It is very hard to comprehend that this young person would take his own life. Kamil came here so that he and his sisters could have a better life in Canada. After he arrived his circumstances changed and he experienced challenges from segments of his family, his community and his culture. Those challenges, along with the impacts of his history before coming to Canada, and the stresses that came from being in a new country, must have been overwhelming.

At the same time, Kamil was described as being proud of his traditional culture, and he took pride in becoming a Canadian. He had people in his life who loved him and cared about him. He had people who worked hard to help him.

Kamil died by suicide. There are other young people in Alberta right now who are experiencing similar challenges, impacts or stresses. They need the improvements outlined in these recommendations and they need them urgently. The findings in this Investigative Review need to be considered and the recommendations must be acted upon.

I want to thank all those who contributed to this report. I also want to say that, while we were not able to have direct contact with his family; I want them to know we are deeply saddened by the loss of their loved one.

I remain hopeful that a small measure of solace can be found in our effort to learn from this circumstance to prevent similar tragedies like this from happening in the future.

[original signed by Del Graff]

Del Graff
Child and Youth Advocate

APPENDIX 1: TERMS OF REFERENCE
INVESTIGATIVE REVIEW – KAMIL

Date of Incident

Summer 2012

Incident

In the summer 2012, Kamil was found deceased by his oldest sister. Kamil had committed suicide by hanging. At the time of the incident he was subject to a Permanent Guardianship Order and was placed with his sister and her boyfriend in a supported independent living arrangement.

The decision to conduct an investigation was made by Del Graff, Child & Youth Advocate in November 2012.

Issues for Investigation

- **Relationships** – What supports were provided to Kamil to understand his role within the sibling group? How were Kamil's other significant relationships supported and encouraged (for example - with his mother who was still in a Middle Eastern country or with previous caregivers)
- **Education** – What educational opportunities were explored for Kamil to develop his English language skills? And, what supports was he provided in the school system?
- **Cultural connections** – As an immigrant youth in Canada, what supports and services were provided to Kamil to transition from one culture to another?
- **Substance Abuse** – Kamil had a severe substance abuse issue; what supports were being provided?
- **Medication** – How was medication approved for Kamil and what factors were considered?
- **Therapeutic intervention** – Kamil had a number of mental health diagnoses which involved a number of mental health and medical professionals. How were services coordinated between the various professionals and how was service provided to this youth for on-going mental health concerns and suicidal ideation?

Scope of the Investigation

The investigation will examine:

- The on-going assessment process used in determining risk and identifying services;
- The coordination of services;
- The ongoing monitoring, services and supports provided to the youth and family;
- The cultural considerations, appropriateness and effectiveness of services; and
- The child intervention standards and any other procedural obligations.

Method

The investigation will be conducted through:

- A review of the electronic and paper files;
- Interviews with CFSA staff and other relevant service providers as required;
- A review of best practices
- Consultation with an expert in teen suicide and addictions.

Investigation Plan

A detailed investigation plan will be developed detailing the steps that will be taken, the individuals who are to be interviewed, additional documents that will be requested and reviewed; and, the questions/issues that will be explored.

Review Board (proposed)

Chair

- Del Graff, Child & Youth Advocate

Members (to be determined but may include)

- A representative from the multi-cultural community
- An expert in the area of adolescent mental health
- An educator with experience/expertise with new immigrants
- A representative from the Alberta College of Social Workers (ACSW) with experience/expertise in the area of child welfare and best practice

Team

To be determined

Reporting

The Child & Youth Advocate will release a non-identifying public report when the investigative review has been completed.

APPENDIX 2: COMMITTEE MEMBERSHIP

Dr. Jerry Yager, PsyD

Dr. Yager is the Director of Training and Education at Denver Children's Advocacy Center (DCAC). He is a Clinical Psychologist with more than 25 years of experience in the assessment and treatment of traumatized children and adolescents. He specializes in working with adolescents who exhibit self-destructive behavior and have severe mental illness. Before joining DCAC he was the Executive Director of the Denver Children's Home, which provided high quality mental health care for low-income children whose problems would otherwise go undiagnosed and untreated.

He received his Doctorate in Psychology from Nova University and A Bachelor of Arts in Psychology from the University of Colorado. He is a Child Trauma fellow with the Child Trauma Academy, and conducts professional training in Colorado and nationally.

In his current position, Dr. Yager is leading the expansion of DCAC's training program for mental health professionals and community members, with a dual focus on child abuse prevention and the assessment and treatment for child trauma. By providing high quality training, DCAC's goal is to create a seamless web of care for children in Colorado.

Dr. Sophie Yohani, PhD., R Psychologist

Dr. Yohani is a registered psychologist and an associate professor of Counselling Psychology at the University of Alberta. She is the director of the Counselling Centre's Clinical Services, a university-based community training centre for graduate students where she teaches graduate courses in Counselling Psychology.

She has a background in counselling psychology, global mental health, elementary education and experience in community psychology, program development and community based research. She maintains a special interest in childhood and adult trauma and the experiences of hope and resiliency. She is interested in the mental health outcomes of refugee and immigrants based on pre- and post-migration experiences and program/policy implications in educational and community settings. She is also interested in the perceptions of trauma, loss and adaptation from the perspective of survivors and helping professionals who work with diverse and underrepresented populations.

Dr. Yohani's focus on trauma and adaptation stems from practice that has involved work in private practice, at a Centre for Survivors of Torture and Trauma and a community-based War Rape Initiative. She is currently exploring the role of multicultural educational brokers in facilitating the adaptation of refugee children in school settings.

Dr. Vinesh Gupta

Dr. Gupta is an Adolescent Forensic Psychiatrist currently working at Alberta Hospital Edmonton for the last 5 years. He is also the Director of Division of Child and Adolescent Psychiatry and the Program Director for Child and Adolescent Psychiatry Residency Training Program at the University of Alberta.

Dr. Gupta has worked/trained across three different countries and continents. After completing his MBBS and Diploma in Psychological Medicine from India he moved to the UK in 1998. Dr. Gupta trained as a Child Psychiatrist and a Forensic Psychiatrist in UK before moving to Canada in 2008.

He has worked exclusively with young offenders since 2006 and has appeared as an expert witness in courts on a number of occasions. He is passionate about providing support for and improving access to services for this most vulnerable population of the society.

Kellie Kilpatrick

Early in her career, Ms. Kilpatrick worked as a social worker at Woodlands School and in the Downtown East Side of Vancouver. Over the following sixteen years, she was assigned numerous secondments that included small First Nations communities and being imbedded within the Nanaimo RCMP. There, she was involved in conducting investigations into allegations of criminal child abuse across BC.

After leaving the front line in 1996, Ms. Kilpatrick took on the role of Practice Analyst and was responsible for conducting internal investigations and high profile case reviews of child deaths and other critical incidents. She was appointed to the Child Welfare League of Canada's Roster of Case Review Experts.

Ms. Kilpatrick completed a term as British Columbia's Deputy Director of Child Welfare and Project Manager for the significant review of the child welfare system. In 2007, Ms. Kilpatrick was appointed as Chair and Executive Director of the Child Death Review Unit at the Office of the Chief Coroner. There, she created the multi-disciplinary framework for the review of all child deaths, a model that was recognized internationally.

In 2011, Ms. Kilpatrick took on the role of Executive Director of the Transition Team, created to support the start-up of the Independent Investigations Office of BC. She currently is the Executive Director of Public Accountability for the IIO.

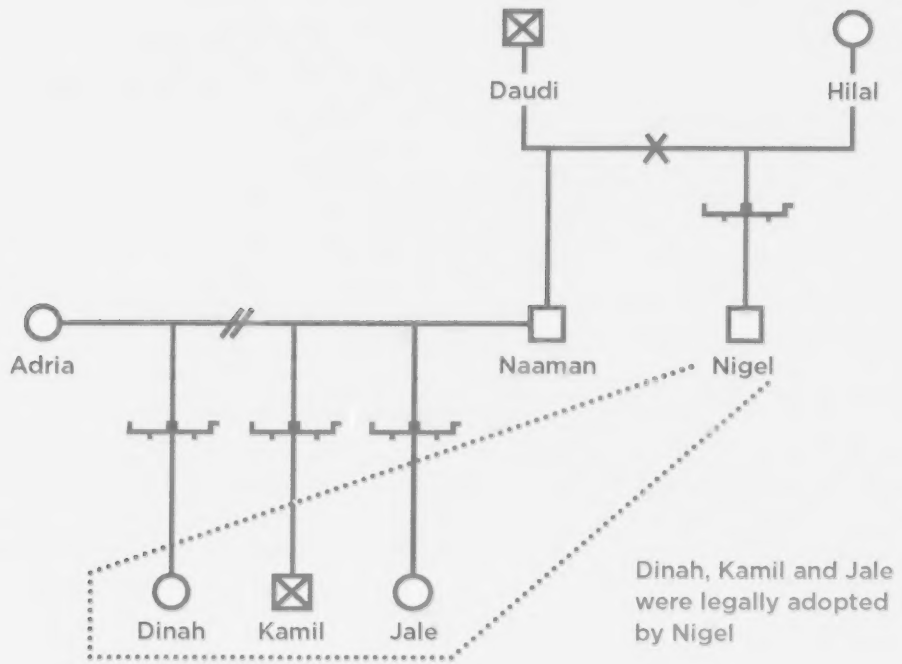
In addition, Ms. Kilpatrick maintains a small private practice that allows her to remain connected to the child welfare landscape. Most recently, she has worked for Nenan Child and Family Services in Ft. St. John and now is pleased to be working with the Alberta Office of the Child and Youth Advocate.

Del Graff, MSW, RSW (Committee Chair)

Del is the Child and Youth Advocate for the Province of Alberta. He has worked in a variety of social work, supervisory and management capacities in communities in B.C. and Alberta. He brings experience in residential care, family support, child welfare, youth and family services, community development, addictions treatment and prevention services. He has demonstrated leadership in moving forward organizational development initiatives to improve service results for children, youth and families.

APPENDIX 3: GENOGRAM

Family Genogram - Kamil



Legend

APPENDIX 4: SUMMARY OF EVENTS

0 – 12 years old
Lived in a country outside Canada. Was adopted by a relative and moved to Canada.

13 years old
Allegations of sexual abuse of oldest sister by a relative; apprehended and placed in a foster home for 10 days.

13 years old
Placed with family friends for 40 days; moved to foster home for 95 days due to behaviours.

13 years old
Moved to group home for 9 months due to behaviours; diagnosis of fear-based type Post Traumatic Stress Disorder; placed on medication.

14 years old
Permanent Guardianship Order granted. Moved from group home to foster home with his siblings.

14 years old
Moved from foster home after 30 days; placed in the White foster home; arrangements made for mental health involvement.

14 years old
Emergency Protection Order issued against relative; several suicide attempts and puts himself at risk.

15 years old
Placed in residential facility; two different medications prescribed but not approved; continued involvement with mental health.

15 years old
After 71 days in a residential facility returned to the White foster home; continued mental health involvement.

16 years old
Child psychiatrist concerned regarding lack of medication which puts him at significant risk to hurt himself or others; medication approved.

16 years old
Kamil is moved from the White home; is assessed to be at risk of suicide; is placed with his sister.

16 years old
Not following through with mental health appointments; smoking marijuana daily.

17 years old
Has argument with his sister; states he took 15 Resperdone pills; refuses to attend hospital.

17 years old
Sister agrees to take Kamil overnight; Kamil returns to his sister's home.

17 years old
Kamil is found deceased in his sister's home.

APPENDIX 5: REFERENCES & BIBLIOGRAPHY

References

Alberta Human Services (2011). Enhancement Policy Manual Intervention Section 9.1.2 Medication and Therapy Requiring Consents

Alberta Human Services (2011). Enhancement Policy Manual Intervention Section 9.1.12 Medication Management

Bibliography

Alberta Human Services (2011). Enhancement Policy Manual Intervention Section 7.3.5 Maintaining a Child's Culture in Placements

American Academy of Child & Adolescent Psychiatry , A. A. (February 2012). *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents.* AACAP.

Dutton, D.G. AND Painter, S.L. (1981) Traumatic Bonding: development of emotional attachments in battered women and other relationships of intermittent abuse. Victimology: An International Journal. 1(4), pp 139 -155

Lambe, Y., & McLeannan, R. (2009). *Drugs in Our System: An Exploratory Study on the Chemical Management of Canadian Systems Youth.* Ottawa: National Youth in Care Network.

Mackenzie,Ian K. (February 2004), The Stockholm Syndrome Revisited: Hostage, Relationships, Prediction, Control and Psychological Science. Journal of Police Crisis Negotiations 4(1): 5-21

Ngo, H. V. (2004). *Immigrant Children in Focus: A Map of Needs, Strategies and Resources.* Calgary: Coalition for equal Access To Education.

Northeastern University School of Law, L. S. (March 2011). *Court-Ordered Consent: Revisiting the Rogers Process for Children in State Custody.*

Solchany, JoAnne (2011) *Practice & Policy Brief: Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges.* Center on Children and the Law.

KAMIL: AN IMMIGRANT YOUTH'S STRUGGLE